Washington State Department of Social & Health Services
DDD Division of Developmental Disabilities

DDD CRISIS DIVERSION BED REFERRAL AND INTAKE INFORMATION

CLIENT'S FULL NAME		DATE OF BIRTH	SOCIAL SECURITY NUMBER
NAME OF PERSON MAKING REFERRAL	TELEPHONE NUMBER	☐ CDMHP ☐ Other ☐ DDD	
DDD CASE RESOURCE MANAGER		DDD/MH CRM TELEPHONE NUMBER	
RESIDENTIAL AGENCY PROVIDER		PROVIDER TELEPHONE NUMBER	
FAMILY/LEGAL REPRESENTATIVE		☐ Medicaid ☐ Medicare ☐ Medicare Part D Provider:	

Current Housing Situation

Communication Style (nonverbal/verbal, primary language, preferred modes):

Diagnosis:

Briefly describe why this person is being referred. List current symptoms/behaviors of concern (define and state frequency and severity of each symptom/behavior).

History of Violent/Dangerous Behaviors and No Contact Orders:

History of Fire-Setting:

History of Sexual Abuse/Assault:

History of Substance Abuse:

History of Vandalism/Destructive Behavior:

Legal History (DOC, jail, mental health commitments, chemical dependency commitments):

Is person on a Court Order or LRA? ☐ Yes ☐ No	NAME OF CORRECTIONS/PAROLE OFFICER	TELEPHONE NUMBER

Previous Mental Health Involvement:

MEDICATION	DOSAGE	AMOUNT	Describe all known allergies:

Describe all Known Physical and Medical Problems:

Describe all Known Treatments:

CURRENT GENERAL PHYSICIAN	TELEPHONE NUMBER
CURRENT MH PRESCRIBER	TELEPHONE NUMBER

Is the person ambulatory? ☐ Yes ☐ No

Does the person use a prosthetic device? ☐ Yes ☐ No
If yes, describe:

Is the person willing to take medications as prescribed? ☐ Yes ☐ No

Date of last medication review:

Known Appointments Scheduled (who/where/when):

Treatment Plan/Goals for the Person.

Other important information:

Discharge Plans:

Hobbies/Interests:

Favorite Foods:

Favorite Places:

Dislikes:

Information Checklist:

- ☐ Fax/Send Signed Physician's Orders
- ☐ Cross System Crisis Plan
- ☐ Functional Assessment
- ☐ Positive Behavior Support Plan
- ☐ POC/ISP
- ☐ Psychiatric/Psychological Evaluation
- ☐ Treatment Plan
- ☐ Guardianship Documentation
- ☐ Current Medication Record

SIGNATURE OF PERSON COMPLETING FORM	TITLE	DATE

TO BE FILLED OUT BY CRISIS DIVERSION BED PROVIDER

Person accepted? ☐ Yes ☐ No

Who is transporting the person?

PROVIDER SIGNATURE	TITLE	DATE